PRINTED: 09/10/2010 FORM APPROVED OMB NO. 0938-0391

NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185259	B. WING	***************************************	07/29/2010
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	TREET ADDRESS, CITY, STATE, ZIP CODE  5301 BASS ROAD  PROSPECT, KY 40059  PROVIDER'S PLAN OF CORREC  (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	CTION. (X5) DULD BE COMPLETION
Amended CMS 256 09/10/10.  A standard health si were initiated on 07/07/29/10. Complain be unsubstantiated, initiated and concluding the facility not to be Life Safety Code, 20 cited with the highes "F".  483.15(b) SELF-DE MAKE CHOICES  The resident has the schedules, and health her interests, assess interact with member inside and outside the about aspects of his are significant to the  This REQUIREMENT by: Based on observation review, it was determallow one (1) of ninet to make choices about to live outside of the findings include: Review of the clinical revealed the resident or rehabilitation of a diagnoses for the resident resident resident or rehabilitation of a diagnoses for the resident re	TL issed to facility on  urvey and abbreviated survey 27/10 and concluded on It KY 00014703 was found to A life safety code survey was ded on 07/29/10 and found in compliance with NFPA 101 00 Edition. Deficiencies were It deficiency identified at an  TERMINATION - RIGHT TO  right to choose activities, th care consistent with his or ments, and plans of care; s of the community both e facility; and make choices or her life in the facility that resident.  T is not met as evidenced  n, interview and record lined the facility failed to sen (19) sampled residents ut the aspects of his/her life acility. (Resident #9)  record for Resident #9 was admitted on 04/30/07 fractured hip. The	F 242	Statement of Deficiencies and puthis Plan of Correction to the ext the summary of findings is factured correct and in order to maintain compliance with applicable rules provisions of the quality of care residents. The Plan of Correction submitted as a written allegation compliance. Britthaven's responstatement of Deficiencies and Pl Correction does not denote agree with the Statement of Deficiencies that any deficiency is accurate.	arposes cent that ally s and of n is of se to this an of ment es nor Further, cfute any mal d s iated by our has

Any delicency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

farker tuner

Event ID: GUED11

program participation.

PRINTED: 09/10/2010 FORM APPROVED OMB NO, 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	TIPLE CONSTRUCTION	(X3) DATE S	
	,		A. BUILD	DING		
		185259	B. WING		07/2	9/2010
	PROVIDER OR SUPPLIER AVEN OF PROSPECT	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Osteo-arthritis, Den facility completed al (MDS) assessment Resident #9 was resident #9 was incompleted al (MDS) assessment Resident #9 was incompleted observation on 07/28 Continued observations are ident ambulated lighter with no staff are ident was observable her self. The resident was observable her self. The resident was observable in the continued of the lighter with no staff are identifications. Throughout the lighter with the lighter with the lighter with the lighter with the lighter of the lighter with	nentia, and Anxiety. The nannual Minimal Data Set on 01/20/10 which indicated sponsible for self.  27/10 at 4:30pm revealed dependent with meals and did protector while he/she ate. on at 5:00pm revealed the outside with clgarettes and supervision. On 07/28/10 the ed in the dining room feeding sident was clean and free of	F 24	Current residents will be interviewed by our Social to ensure each resident is a to make their own choice a aspect of their life to live of the Nursing Facility. Resi will continue to be assesse through the R.A.I. process quarterly, annually & with significant change in their condition to ensure they are allowed to make their own about the aspect to live out the facility.	allowed about the outside of dents d es any e choice	
t e v	related that after recibe/she has been total activities of daily living once in three (3) year revealed he/she had the facility with two (2) to the current social vevealed that he/she worker and requested a boarding room but was not possible and dessert drying up being the boarding to 07/28/10 Worker revealed she liscussion with Reside alternate housing.	overy from the fractured hip ally independent with g and only using the call light rs. The resident further expressed a desire to leave e) other social workers prior worker. Resident #9 spoke with the current social d to leave the facility and go until he/she was able to find the resident was told that stated " I feel like I'm in a		Facility staff will be re-edu- the Director of Nursing on 26, 2010 regarding residents to include that all residents the right to choose activities schedules, and health care consistent with his or her in assessments, and plans of co- interact with members of the community both inside and of the facility; and make che about aspects of his or her late the facility that are significate the resident and that the Social	August 's rights have s, terest, are; e outside pices ife in nt to	

FORM CMS-2587(02-99) Previous Versions Obsoleto

Event ID: GUED11

, Facility ID: 100430

If continuation sheet Page 2 of 6



PRINTED: 09/10/2010 FORM APPROVED OMB NO. 0938-0391

	nt of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED.
		185259	B. WING		07/29/2010
	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059	
(X4) ID PREFIX TAG	(BACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 250 SS=D	the resident has alw responsible person housing expressed in option.  Interview on 07/29/1 Administrator reveal Resident #9's desired Administrator further would need a better suggested.  Telephone interview Licensed Practical Nobeen employed for a stated that she is ver She reported the resident had desire to leave the fawere left with the Socresident's desire to leave the fawere left with th	ne Social Worker stated that ays been his/her own and indicated the alternate by the resident was not an 0 at 3:00pm with the ed he was unaware of to leave the facility. The stated that the resident option than the ourrent one on 07/29/10 at 8:30pm with urse #3 revealed she has even (7) months. The LPN y famillar with Resident #9. Ident's need was medication tated that she has never #9 confused. She reported stated several times of the cility. She related that notes stall Worker, which stated the ave the facility. SION OF MEDICALLY SERVICE ide medically-related social halntain the highest mental, and psychosocial sident.	F 24	Worker and the Director of Nursing must be made awar resident expresses a desire to the facility to ensure proper discharge planning can be in A random monthly Q.I. and be initiated by the Director of Nursing to ensure resident's choices about the aspects of life to live outside the facility being honored and that discharge planning has been initiated a appropriate with corrective at taken as necessary. The result these Q.I. audits will be reviewed to the Administrator and the Medical Director in the mon Q.I. meetings.	o leave  nitiated. it will of  his/her y are harge as actions alts of cwed he thly
	•				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GUED11

Facility ID: 100430

REC Economistical sheet Page 3 of 6

SEP 1 0 2010

OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES

#### PRINTED: 09/10/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 185259 07/29/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6301 BASS ROAD** BRITTHAVEN OF PROSPECT PROSPECT, KY 40059 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ID PREFIX (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) F 250 Continued From page 3 F 250 F-250 continued; for one (1) of nineteen (19) sampled residents. Resident #9 falled to get assistance in obtaining a An audit of current residents will social security card for discharge back to the be completed by the Admissions community. Director to ensure residents have The findings include: received medically related Social Services assistance to obtain a Review of the clinical record for Resident #9 social security card if needed. Any revealed the resident was admitted on 04/30/07 for rehabilitation for a fractured hip. The resident who does not have a social diagnoses for the resident included security card will be provided Osteo-arthritis, Dementia and Anxiety. The assistance to obtain one. New facility completed an annual Minimal Data Set residents will continue to have (MDS) assessment on 01/20/10 which indicated the resident was responsible for self. medically related social services provided upon admission to obtain Interview with Resident #9 on 07/28/10 at social security cards as needed. 10:00am revealed the resident was admitted for rehabilitation with a hip fracture in 03/07. The resident reported he/she has been totally The Admissions Director and independent with activities of daily living since Social Services Director will be rerecovery. The resident stated he/she had only educated by the Director of used the call light once in three (3) years. The Nursing and / or the Administrator resident reported his/her desire to leave the facility with two other social workers prior to the on 8/26/2010, to provided current social worker. The resident reported medically related social services to he/she requested the help of the social worker to attain the highest practicable obtain a social security card, and as of today the resident has not been assisted in obtaining one. physical, mental, and psychosocial well being of each resident Interview with the Social Worker on 07/28/10 at including providing assistance in 12:00pm revealed she was unsure of Resident obtaining a social security card for #9's need for a social security card. The Social discharge back into the Worker revealed that she would be willing to assist the resident now. Also, the Social Worker community. revealed that she had started on possible

FORM CMS-2567(02-99) Provious Versions Obsolete

discharge placement as of Monday 07/26/10. The Social Worker revealed that no discharge planning had been assessed for the resident prior

Event ID: GUED11

Facility ID: 100430

If continuation sheet Page 4 of 6



OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES #1 \* \* \* \*\*

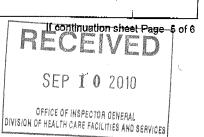
PRINTED: 09/10/2010 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE COMPI	
		185259	B. WING		02/	ח 4חמומנ
	PROVIDER OR SUPPLIER AVEN OF PROSPECT		, t	REET ADDRESS, CITY, STATE, ZIP COD 5301 BASS ROAD PROSPECT, KY 40059		29/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XII) COMPLETION DATE
	to 07/26/10.  Record review on 0 documentation of di (Social Narrative Prosocial service narral 12:25pm discussing transitions agency. 483.15(h)(1) SAFE/CLEAN/COMIENVIRONMENT  The facility must procomfortable and hon	7/27/10 revealed no scharge planning. The record ogress Note) revealed a ive dated 07/28/10 at possible discharge to a state FORTABLE/HOMELIKE vide a safe, clean, nelike environment, allowing is or her personal belongings	F 250	F-250 continued; A random monthly Q.I. a be initiated by the Director Nursing to ensure each refreceived medically related services assistance to obtational security card if need corrective action taken as necessary. The results of audits will be reviewed we Administrator and Medical Director in the Monthly Quantities Meeting.  Completion Date; Augus 2010	or of sident has d social ain a ded with these al	
tin al	by: Based on observation determined the facility clean, homelike environ botential of safety rish substance located are uneven floor surface in all entrance which le and an uneven surface all entrance.  The findings include:  Observations during in 7/29/10 at 2:30pm re and 53 had a black su the toilets in those roo the residents' bathro t 4:20pm the same de	n and interview it was a failed to provide a safe, comment free from the as related to a black bund the base of toilets, an ocated between the front ads to the nurse's station, it is in front of the third street with strong urine smells from the strong urine smells from the Maintenance and the Maintenance and the many with the Maintenance and the safe of the strong with a change	1	F-252  The commodes in rooms of 50, and 53; have been take floor area cleaned thoroug tile replaced as needed. The commode was replaced with wax seal and anchor bolts, commode was sealed around bottom edge with a bead of silicone caulk. The Mainte Director and Housekeeping Supervisor will continue the process on a regular scheduall commodes in the facility need to be resealed, has becompleted.	en up, the hly and he ith a new The nd the fenance site until y that	

FORM CMS-2567(02-99) Provious Versions Obsolete

Event ID; GUED11

Facility ID: 100430



DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES				DDINITE	TD. 00445-
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOR	D: 09/10/201 M APPROVE
SIAIRMEN	VI OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				OMB N	O. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BL		TIPLE CONSTRUCTION NG	(X3) DATE	SURVEY
,		185259	B. WI	NG .			
NAME OF	PROVIDER OR SUPPLIER	, 40100		1		07/	/29/2010
	AVEN OF PROSPECT			€	REET ADDRESS, CITY, STATE, ZIP CODE 301 BASS ROAD PROSPECT, KY 40059		
(X4) ID PREFIX TAG	(CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC  (EACH CORRECTIVE ACTION SHO  CROSS-REFERENCED TO THE APPR  DEFICIENCY)		(X5) COMPLETION DATE
i i i i i i i i i i i i i i i i i i i	station. Observation revealed Resident #1 being assisted by sta got hooked into a circle the third street hallwain the shower-chair aresident placed her have been a fall from occatated "Oops there go nterview with the Mail 7/29/10 at 4:05pm ree pulled up and resea lousekeeping can cle ubstance would not cout the uneven floor or all, the Maintenance I urveyor could just writ	nches located between the which leads to the nurse's on 07/27/10 at 4:00pm 3 was in a shower-chair off; the shower-chair wheel pular dip in the floor, outside y. Resident #13 fell forward the staff pushing the lead in front of the resident curring. Resident #13 less the hole again."  Intenance Director on vealed the tollets needed to all day and the black ome up. After being asked in the front hall entrance lutside of the third street Director stated that the le it up and they would fix	e rd to	t	F-252 Continued;  The transition strip in the from entrance hallway has been reserved with a ten inch wide stainless panel that will form a ramp between the two areas of the hallway. This ramp will remany tripping hazard and will for easier access thru the hall for those residents in wheeled. The circular floor drain in the near the nurse's station on The Street hallway; has been cover with a removable 12 inch stainsteel cover that matches up with the surrounding tile to form flow mooth surface. The addition.	eplaced s steel  aove allow way nairs.  area aird ered nless ith at al	
aw a c bei fun	rare of Resident #13's fip in the floor outside ing pushed in shower ther stated that she h	tor of Nursing (DON) on ealed that she was not a shower-chair tipping, into sof third street hall, while chair by staff. The DON as no record of falls a dip in the floor outside		ti ti ti	loor drains in the facility have een checked and do not pose ipping or tipping hazard becamey are level with the surroun le and form a flat, smooth urface.	a ause	
with sma Adn	Jpm revealed he was	ed that the din in the		C 20	ompletion Date August 27, 110		



SEP 1 0 2010

PRINTED: 08/11/2010 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE S COMPLI	
		185259	B. WING		07/2	9/2010
	PROVIDER OR SUPPLIER  AVEN OF PROSPECT			REET ADDRESS, CITY, STATE, ZIP CC 3301 BASS ROAD PROSPECT, KY 40059		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 242 SS=D	A standard health s were initiated on 07 07/29/10. Complain be unsubstantiated initiated and conclust the facility not to be Life Safety Code, 20 cited with the higher "F".  483.15(b) SELF-DEMAKE CHOICES  The resident has the schedules, and healther interests, assess interact with member inside and outside the serior of th	survey and abbreviated survey 1/27/10 and concluded on not KY 00014703 was found to. A life safety code survey was ded on 07/29/10 and found in compliance with NFPA 101 000 Edition. Deficiencies were st deficiency identified at an ETERMINATION - RIGHT TO the right to choose activities, alth care consistent with his or sments, and plans of care; ers of the community both the facility; and make choices to rher life in the facility that	F 000	Britthaven acknowledges rec Statement of Deficiencies an this Plan of Correction to the the summary of findings is fa correct and in order to mainta compliance with applicable r provisions of the quality of c residents. The Plan of Corrections and the provisions of the quality of c residents. The Plan of Corrections and the provisions of the plan of Corrections and the provisions of the plan of Correction does not denote any with the Statement of Deficiencies and the Statement of Deficiency is accurated britthaven reserves the right of the Deficiencies through In Dispute Resolution, formal approcedures and/or any other administrative or legal process.	d purposes e extent that actually ain rules and are of ction is tion of sponse to this d Plan of greement encies nor e. Further, to refute any informal ppeal	
	by: Based on observation review, it was determallow one (1) of nine to make choices about o live outside of the The findings include Review of the clinical revealed the resident for rehabilitation of a diagnoses for the resident of the costeo-arthritis, Deministration of the costeo-arthritis, Deministration of the resident of the re	Il record for Resident #9 t was admitted on 04/30/07 fractured hip. The		AUG	010 by our t #9 has	

Any deficiency statement ending with an asterist \*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

5N

PRINTED: 08/11/2010 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE S COMPL	
			j		-	
		185259	B, WIN	G	07/2	29/2010
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 6301 BASS ROAD PROSPECT, KY 40059	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
t a st	Observation on 07/2 Resident #9 was incomot require clothing Continued observation resident ambulated lighter with no staff some resident was observed in the resident was observed. The resident was observed in the resident was observed in the resident was observed. The resident was observed in the resident was not possible and dessert drying up being the revealed she worker and requested in the resident was not possible and dessert drying up being the revealed she worker revealed she worker revealed she worker and requested in the revealed she worker revealed she worke	sponsible for self.  27/10 at 4:30pm revealed dependent with meals and did protector while he/she ate. ion at 5:00pm revealed the outside with cigarettes and supervision. On 07/28/10 the ed in the dining room feeding sident was clean and free of the day the resident hout assistance and was with Activities of Daily Living.  O at 10:00am with Resident was admitted for rehabilitation ure hip in 2007. The resident overy from the fractured hip ally independent with ag and only using the call light rs. The resident further expressed a desire to leave 20 other social workers prior worker. Resident #9 spoke with the current social d to leave the facility and go until he/she was able to find the resident was told that stated " I feel like I'm in a ng here ".  O at 12:00pm with the Social was unsure of having a lent #9 regarding discharge She further stated that resident was experiencing social Worker stated that	F 24	F-242 continued; Current residents wi interviewed by our Sto ensure each resident to make their own chaspect of their life to the Nursing Facility. will continue to be at through the R.A.I. proparties of the significant change in condition to ensure the allowed to make their about the aspect to lift the facility.  Facility staff will be resident to include that all resist the right to choose accesshedules, and health consistent with his or assessments, and plant interact with members community both inside of the facility; and matabout aspects of his of the facility that are significant and that the resident and that the significant continued that all resist the resident and that the resident and that the resident and that the resident and that the significant resident and that the resident and that the significant resident and that the resident and	Social Worker ent is allowed noice about the live outside of Residents seessed rocesses with any their hey are rown choice we outside of re-educated by ng on August sident's rights dents have tivities, care her interest, as of care; s of the le and outside ake choices r her life in gnificant to	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GUED11

Facility ID: 100430

If continuation sheet Page 2 of 8

AUG 2 0 2010

PROGRESSION OF CONTROL OF THE CONTROL OF THE CASE PROBLEM OF THE SERVICES

PRINTED: 08/11/2010 FORM APPROVED OMB NO. 0938-0391

1	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	COMPL	ETED
		185259	B. WING_		07/2	9/2010
	PROVIDER OR SUPPLIER  AVEN OF PROSPECT			REET ADDRESS, CITY, STATE, ZIP CODE 3301 BASS ROAD PROSPECT, KY 40059		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 242	1	ge 2 by the resident was not an	F 242	r-242 continued;		
SS=D	Interview on 07/29/1 Administrator reveal Resident #9's desire Administrator furthe would need a better suggested.  Telephone interview Licensed Practical Nobeen employed for stated that she is vereally stated that she is vereally she witnessed Resident that the resident had desire to leave the fawere left with the Soresident's desire to leave the fawere left with the Soresident's desire to leave the fawere left with the Soresident's desire to leave the fawere left with the Soresident's desire to leave the facility must propose to attain or inservices to attain or inservices to attain or inservices in the services	SION OF MEDICALLY SERVICE  vide medically-related social maintain the highest mental, and psychosocial	F 250	Worker and the Director of Nursing must be made awar resident expresses a desire to the facility to ensure proper discharge planning can be in A random monthly Q.I. audibe initiated by the Director of Nursing to ensure resident's choices about the aspects of life to live outside the facility being honored and that disched planning has been initiated a appropriate with corrective at taken as necessary. The resurthese Q.I. audits will be review the Administrator and the Medical Director in the mon Q.I. meetings.  Completion Date; August 3 2010	o leave nitiated. it will of his/her y are narge us actions ults of ewed he thly	
	by: Based on interview a determined the facilit medically-related soc for one (1) of ninetee Resident #9 failed to	r is not met as evidenced  nd record review, it was y failed to ensure ial services were provided n (19) sampled residents. get assistance in obtaining a or discharge back to the		F-250  Application for a new social security card for resident #9 vinitiated by our Social Service Director on 8/6/2010.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GUED11

Facility ID: 100430

If continuation sheet Page 3 of 8



PRINTED: 08/11/2010 FORM APPROVED OMB NO. 0938-0391

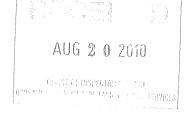
		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE S	
BRITTHAVEN OF PROSPECT    STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059    CALL OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CALL CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    F 250   Continued From page 3 community.   F 250   F-250 continued;   The findings include:			185259	B. WIN	G		07/	29/2010
PRÉFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 250  Continued From page 3 community.  The findings include:  Review of the clinical record for Resident #9 revealed the resident was admitted on 04/30/07 for rehabilitation for a fractured hip. The diagnoses for the resident included Osteo-arthritis, Dementia and Anxiety. The facility completed an annual Minimal Data Set (MDS) assessment on 01/20/10 which indicated the resident was responsible for self.  Interview with Resident #9 on 07/28/10 at 10:00am revealed the resident was admitted for rehabilitation with a hip fracture in 03/07. The resident reported he/she has been totally  F 250  F-250 continued;  An audit of current residents will be completed by the Admissions Director to ensure residents have received medically related Social Services assistance to obtain a social security card if needed. Any resident who does not have a social security card will be provided assistance to obtain one. New residents will continue to have medically related social services provided upon admission to obtain	1				63	01 BASS ROAD	1	10/2010
Community.  The findings include:  Review of the clinical record for Resident #9 revealed the resident was admitted on 04/30/07 for rehabilitation for a fractured hip. The diagnoses for the resident included Osteo-arthritis, Dementia and Anxiety. The facility completed an annual Minimal Data Set (MDS) assessment on 01/20/10 which indicated the resident was responsible for self.  Interview with Resident #9 on 07/28/10 at 10:00am revealed the resident was admitted for rehabilitation with a hip fracture in 03/07. The resident reported he/she has been totally  An audit of current residents will be completed by the Admissions Director to ensure residents have received medically related Social Services assistance to obtain a social security card if needed. Any resident who does not have a social security card will be provided assistance to obtain one. New residents will continue to have medically related social services provided upon admission to obtain	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	<b>(</b>	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
Review of the clinical record for Resident #9 revealed the resident was admitted on 04/30/07 for rehabilitation for a fractured hip. The diagnoses for the resident included Osteo-arthritis, Dementia and Anxiety. The facility completed an annual Minimal Data Set (MDS) assessment on 01/20/10 which indicated the resident was responsible for self.  Interview with Resident #9 on 07/28/10 at 10:00am revealed the resident was admitted for rehabilitation with a hip fracture in 03/07. The resident reported he/she has been totally  be completed by the Admissions Director to ensure residents have received medically related Social Services assistance to obtain a social security card if needed. Any resident who does not have a social security card will be provided assistance to obtain one. New residents will continue to have medically related social services provided upon admission to obtain	F 250		ge 3	F 2	50			
recovery. The resident stated he/she had only used the call light once in three (3) years. The resident reported his/her desire to leave the facility with two other social workers prior to the current social worker. The resident reported he/she requested the help of the social worker to obtain a social security card, and as of today the resident has not been assisted in obtaining one.  Interview with the Social Worker on 07/28/10 at 12:00pm revealed she was unsure of Resident Worker revealed that she would be willing to assist the resident now. Also, the Social Worker revealed that she had started on possible discharge placement as of Monday 07/26/10.  The Social Worker is defined by the Director of Nursing and / or the Administrator on 8/26/2010, to provided medically related social services to attain the highest practicable physical, mental, and psychosocial well being of each resident including providing assistance in obtaining a social security card for discharge back into the community.  Record review on 07/27/10 revealed no		Review of the clinical revealed the resider for rehabilitation for diagnoses for the resident of the control of	al record for Resident #9 Int was admitted on 04/30/07 a fractured hip. The resident included Inentia and Anxiety. The In annual Minimal Data Set In 01/20/10 which indicated Inponsible for self.  In ent #9 on 07/28/10 at In resident was admitted for Inip fracture in 03/07. The Inshe has been totally Itivities of daily living since Intent tent (3) years. The Inshe desire to leave the Insocial workers prior to the Instruction of the social worker to Intentify card, and as of today the In assisted in obtaining one.  Incial Worker on 07/28/10 at Insecurity card. The Social It she would be willing to Instruction of the social worker It security card. The Social It she would be willing to Instruction of the social worker It she would be willing to Instruction of the social worker It she would be willing to Instruction of the social worker It she would be willing to Instruction of the social worker It she would be willing to Instruction of the social worker It she would be willing to Instruction of the social worker It she would be willing to Instruction of the social worker It she would be willing to Instruction of the social worker It she would be willing to Instruction of the social worker It she would be willing to Instruction of the social worker It she would be willing to Instruction of the social worker It she would be willing to Instruction of the social worker I			be completed by the Admis Director to ensure residents received medically related Services assistance to obtain social security card if needed resident who does not have security card will be provide assistance to obtain one. Not residents will continue to he medically related social serror provided upon admission to social security cards as needed. The Admissions Director are Social Services Director will educated by the Director of Nursing and / or the Admin on 8/26/2010, to provided medically related social servatain the highest practicable physical, mental, and psych well being of each resident including providing assistant obtaining a social security of discharge back into the	ssions s have Social n a ed. Any a social ed ew ave vices o obtain ded.  If be re- istrator vices to e osocial ace in	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GUED11

Facility ID: 100430

If continuation sheet Page 4 of 8



PRINTED: 08/11/2010 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		185259	B. WING		07/29/2010
	PROVIDER OR SUPPLIER  AVEN OF PROSPECT			REET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 250 F 252 SS=D	documentation of di (Social Narrative Pri social service narrati 12:25pm discussing transitions agency. 483.15(h)(1) SAFE/CLEAN/COM ENVIRONMENT  The facility must pro- comfortable and hor	scharge planning. The record ogress Note) revealed a tive dated 07/28/10 at possible discharge to a state FORTABLE/HOMELIKE vide a safe, clean, nelike environment, allowing is or her personal belongings	F 250	A random monthly Q.I. audibe initiated by the Director of Nursing to ensure each residureceived medically related subservices assistance to obtain social security card if needed corrective action taken as necessary. The results of the audits will be reviewed with Administrator and Medical Director in the Monthly Q.I. Committee Meeting.	of lent has ocial a d with ese the
·	by: Based on observation determined the facilitic clean, homelike environmental of safety rissubstance located ar uneven floor surface hall entrance which leand an uneven surfachall entrance.  The findings include: Observations during and 53 had a black state to liets in those roof in the residents' bathing at 4:20pm the same of Director, revealed and height of about 2 infront hall entrance, wifront hall entrance, wifront safety in the facilities and the same of the sam	n and interview it was by failed to provide a safe, ronment free from the ks related to a black round the base of toilets, an located between the front reads to the nurse's station, be in front of the third street station of the third street rooms. Observations made between floor with a change ches located between the nurse's on 07/27/10 at 4:00pm		Completion Date; August 3 2010  F-252  The commodes in rooms #2, 50, and 53; have been taken floor area cleaned thoroughl tile replaced as needed. The commode was replaced with wax seal and anchor bolts. To commode was sealed around bottom edge with a bead of silicone caulk. The Mainten Director and Housekeeping Supervisor will continue this process on a regular schedule all commodes in the facility need to be resealed, has been completed.	y and a new The I the ance se until

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GUED11

Facility ID: 100430

If continuation sheet Page 5 of 8



PRINTED: 08/11/2010 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	LTIPLE CONSTRUCTION .	(X3) DATE S	
			A. BUILT			
		185259	B. WING		07/2	9/2010
j	PROVIDER OR SUPPLIER  AVEN OF PROSPECT	<u>-</u>	s	TREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 456	revealed Resident # being assisted by st got hooked into a ci the third street hallw in the shower-chair resident placed her prevent a fall from o stated "Oops there of Interview with the M 07/29/10 at 4:05pm be pulled up and resident the uneven floor about the uneven floor about the uneven floor hall, the Maintenanc surveyor could just wit.  Interview with the Director of Resident # a dip in the floor outs being pushed in show further stated that shoccurring because of the third street hall interview with the Ad 4:50pm revealed her with the caulking arous small dip outside of the Administrator further front doorway has be	raff; the shower-chair wheel reular dip in the floor, outside vay. Resident #13 fell forward and the staff pushing the hand in front of the resident to ccurring. Resident #13 goes the hole again".  aintenance Director on revealed the toilets needed to be sealed around the toilet base. Clean all day and the black to come up. After being asked for in the front hall entrance to outside of the third street to Director stated that the write it up and they would fix rector of Nursing (DON) on revealed that she was not 13's shower-chair tipping, into side of third street hall, while wer-chair by staff. The DON to has no record of falls for the dip in the floor outside lie.  In ministrator on 07/29/10 at was unaware of the issue and the toilet bases and the the third street hall. The stated that the dip in the en an ongoing issue.  FIAL EQUIPMENT, SAFE	F 456	The transition strip in the fentrance hallway has been with a ten inch wide stainle panel that will form a ramp between the two areas of the hallway. This ramp will reany tripping hazard and wife for easier access thru the heart the nurse's station on Street hallway; has been convited a removable 12 inch steel cover that matches up the surrounding tile to form smooth surface. The addit floor drains in the facility heen checked and do not put tripping or tipping hazard they are level with the surrounding tile and form a flat, smooth surface.  Completion Date August 2010	replaced ess steel ne move ll allow allway lchairs. the area Third overed tainless with n flat ional nave ose a pecause ounding	
	The facility must mair	ntain all essential				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GUED11

Facility ID: 100430

If continuation sheet Page 6 of 8



PRINTED: 08/11/2010 FORM APPROVED OMB NO. 0938-0391

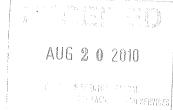
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE S	
		40000	B. WII				
NAME OF	PROVIDER OR SUPPLIER	185259	15. ***	Ι		07/2	9/2010
	AVEN OF PROSPECT		•	63	EET ADDRESS, CITY, STATE, ZIP CODE 301 BASS ROAD ROSPECT, KY 40059		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 456			F	156	F-456 continued;		
	that glucose monito 06/01/10, 06//02/10, checks were perform.  An interview with Lic #1 on 07/27/10 at 4: monitoring system is every shift and logger at nurse's station.  An interview with the 4:45pm revealed the the glucose monitoring 02/2008. The Unit Manusure if blood glucoselsewhere.  An interview with the on 07/28/10 at 7:45a in-serviced her staff glucometers quality in DON also revealed the checks were address meeting. The DON sigucometer quality missing the checks were quality in glucometer quality in glucometer quality missing the checks were address meeting. The DON sigucometer quality missing the checks were quality miss	ring was performed only on , 06/04/10, 06/07/10 all quality			The facility will have the W Clerk / designee review gluchecks daily to ensure nurse completing the test. Ward of designee will report finding Unit manager and the Direct Nursing.  The Director of Nursing / dewill review the Ward Clerk monitoring logs weekly for months, then monthly for 6 to ensure completion and at The glucometer plan of committed will be reviewed at the month Q.I. committer meeting to eneffectiveness.  Completion Date August 1 2010	cometer es are clerk / s to the tor of esignee s months curacy. rection thly nsure	
							1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GUED11

Facility ID: 100430

If continuation sheet Page 8 of 8





NOTE: The following Sample Policy and Procedure is provided only as an example to help your facility establish your own policies and procedures. Your own policy may vary depending upon your facilities existing procedures. Please consult with your Director of Nursing for further direction.

#### **Policy: Quality Control Testing on Assure Pro Meter**

Quality control testing using the Assure Pro Control Solution will be performed to examine the performance of the Assure Pro Blood Glucose Monitoring System.

The Assure Pro Control Solution checks if the meter and test strips are working correctly as a system and if you are testing correctly.

#### **Perform a Control Solution Test:**

- Before testing with the Assure Pro System for the first time
- When you open a new bottle of test strips
- · Whenever you suspect the meter or test strips may not be functioning properly
- If test results appear to be abnormally high or low or are not consistent with clinical symptoms
- The test strip bottle has been left open or has been exposed to light, temperatures below 34°F (4°C) or above 86°F (30°C), or humidity levels above 80%
- To check your technique

When the Assure Pro Meter has been dropped or stored below 32°F (0°C) or above 122°F (50°C).

IMPORTANT: Depending on state regulations, control solution testing may be required on a daily basis. Please check with your local inspector's regulations or facility procedures.

#### Important:

- Assure Pro Control Solution is not intended for human consumption. Do not drink.
- Only use with Assure Pro Blood Glucose Meter and Assure Pro Test Strips.
- NEVER touch tip of control solution bottle to test strip!
- Dye in control solution may stain clothing or surfaces.
- Store the control solution between 59-86°F (15-30°C).
- · Keep away from direct sunlight and heat. Do not freeze or refrigerate.
- Use before the expiration date printed on bottle.
- Use the control solution within 90 days (3 months) of first opening. It is recommended that you write the date of opening on the control solution bottle label ("Date Opened") as a reminder to dispose of the opened solution after 90 days.
- Always replace the cap immediately after use.
- To avoid contamination do not touch the tip of the bottle to the test strip.
- Assure Pro Control Solution is not a cleaning solution. Do not clean your meter with control solution.

Level of Responsibility: RN/LPN



exhibit B

#### - Princh

# COMPLETE IN-SERVICE TRAINING REPORT WITH STAFF ATTENDING

cacility: BOP	Department: NSQ
Date: 11-19-9 Time:	To:
Meeting area: NOSES STATION OON Employee group(s) present: License husses	office
Total number of employees in group(s):	
Number present:	Number not present:
Subject(s) covered: See Attacked	
	·
Problems, comments, suggestions:	
Trobichis, comments, suggestions.	
Conducted by: Janika Gidron R	N ALB 2 7 276
Title: 00 W	
Signature: Lanh Huh RW	Title: